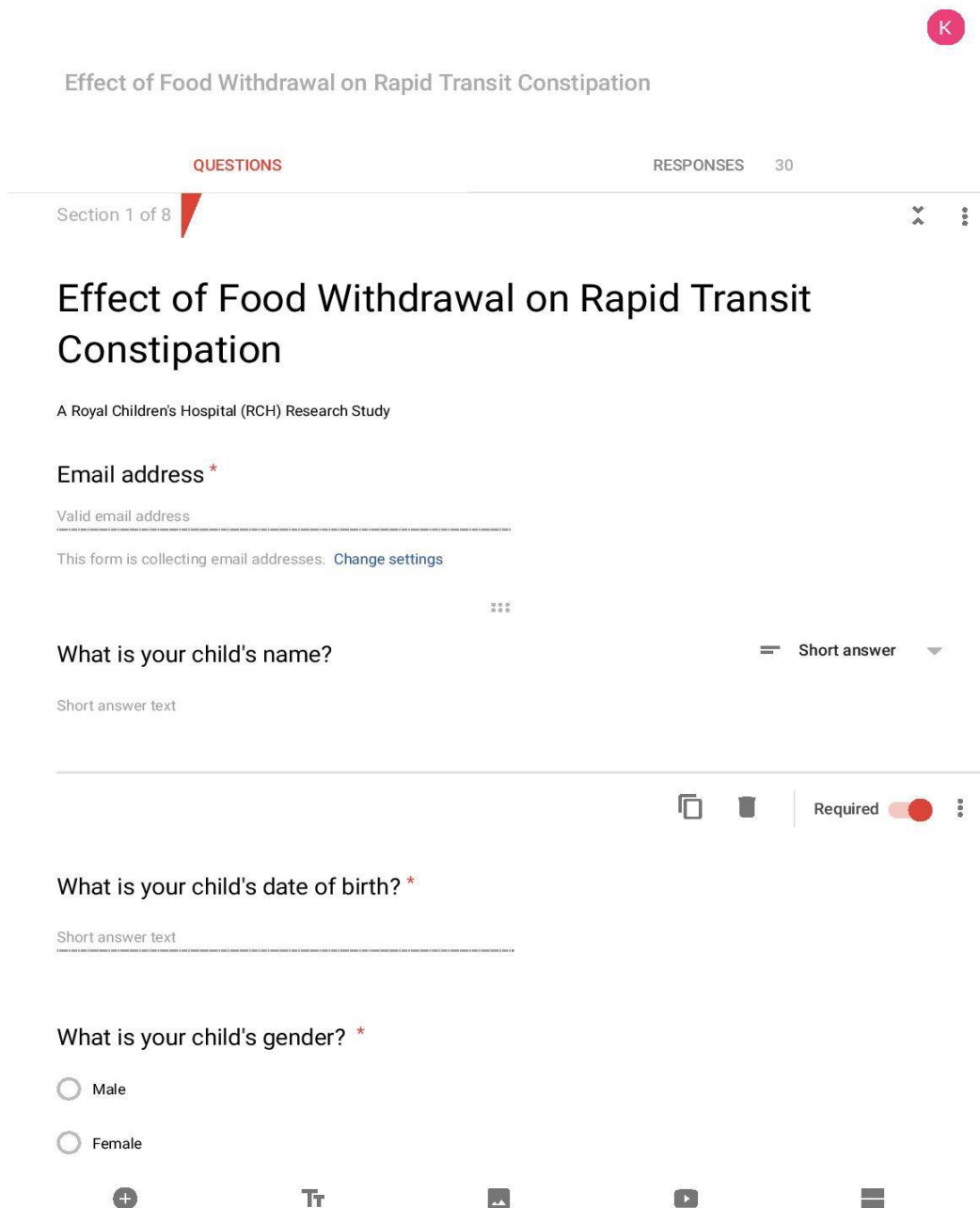


Appendix

Figure 1: The Questionnaire about food exclusion was created as a Google Poll. Families were sent the link and answered online. Email address and child name were collected to identify the patient. Families without Internet answered on the phone.



The image shows a screenshot of a Google Poll interface. At the top right, there is a red circular profile icon with the letter 'K'. The poll title is "Effect of Food Withdrawal on Rapid Transit Constipation". Below the title, it says "Section 1 of 8" and "QUESTIONS" in red, with "RESPONSES 30" to the right. The main heading of the poll is "Effect of Food Withdrawal on Rapid Transit Constipation", followed by the subtitle "A Royal Children's Hospital (RCH) Research Study". The first question is "Email address *", with a text input field containing the placeholder "Valid email address" and a note "This form is collecting email addresses. Change settings". The second question is "What is your child's name?", with a "Short answer" dropdown menu and a text input field. The third question is "What is your child's date of birth? *", with a text input field. The fourth question is "What is your child's gender? *", with radio button options for "Male" and "Female". At the bottom of the poll, there are icons for adding questions, text, images, videos, and a list of options.



Elimination Diet

Description (optional)

Which food group(s) have you eliminated from your child's diet? *

Lactose

Fructose

Other...

How was the elimination diet achieved? *

All trigger foods TOGETHER

Each food INDIVIDUALLY

'FODMAP' diet

Lactose

Please answer questions in this section ONLY if you have eliminated lactose from your child's diet.

Date stopped lactose (MM/YYYY)

Short answer text

BEFORE going on the diet, how often did your child eat foods containing lactose?



- 1 /day
- Twice a week
- Once a week
- Occasionally

Did you eliminate lactose completely?

- Yes
- No

How long did you stick to the diet for?

Short answer text

Did you reintroduce lactose to confirm if it was a trigger?

- Yes
- No

Fructose

Please answer questions in this section ONLY if you have eliminated fructose from your child's diet.

Date stopped fructose (MM/YYYY)

Short answer text

BEFORE going on the diet, how often did your child eat foods containing fructose?



- 1 /day
- Twice a week
- Once a week
- Occasionally

Did you eliminate fructose completely?

- Yes
- No

How long did you stick to the diet for?

Short answer text

Did you reintroduce fructose to confirm if it was a trigger?

- Yes
- No

After section 2 [Continue to next section](#)

Section 3 of 8



Maintenance of the Elimination Diet

Description (optional)

Did you or your child encounter any problems with this elimination diet? *



No (please skip to last question on page)

What problems did you or your child encounter?

Row 1. Did your child dislike the diet?

Row 2. Did it take longer to prepare meals?

Row 3. Is it unachievable with current lifestyle?

Row 4. Was it expensive?

Column 1. Yes

Column 2. No

If you or your child encountered any other problem(s) with this elimination diet, please specify:

Short answer text

Have you seen anyone to help you with your child's diet? *

- No
- Dietician
- Nutritionist
- GP
- Paediatrician
- Family/Friends
- Other...

After section 3 **Continue to next section**





Laxatives

Description (optional)

BEFORE the diet, what laxatives did your child use?

Description (optional)

Laxative 1 (Name, Dose, and Frequency)

Long answer text

Laxative 2 (Name, Dose, and Frequency)

Long answer text

Laxative 3 (Name, Dose, and Frequency)

Long answer text

AFTER the diet, what laxatives does your child use?

Description (optional)

Laxative 1 (Name, Dose, and Frequency)

Long answer text

Laxative 2 (Name, Dose, and Frequency)

Long answer text



Laxative 3 (Name, Dose, and Frequency)

Long answer text

After section 4 **Continue to next section**



Section 5 of 8



Stools








Description (optional)

Image title



THE BRISTOL STOOL FORM SCALE (for children)

choose your POO!

type 1		looks like: rabbit droppings Separate hard lumps, like nuts (hard to pass)
type 2		looks like: bunch of grapes Sausage-shaped but lumpy
type 3		looks like: corn on cob Like a sausage but with cracks on its surface
type 4		looks like: sausage Like a sausage or snake, smooth and soft
type 5		looks like: chicken nuggets Soft blobs with clear-cut edges (passed easily)
type 6		looks like: porridge Fluffy pieces with ragged edges, a mushy stool
type 7		looks like: gravy Watery, no solid pieces ENTIRELY LIQUID

What stool type in the picture above matches your child's stool BEFORE the diet? *

1 2 3 4 5 6 7

What stool type in the picture above matches your child's stool AFTER the diet? *





After section 5 **Continue to next section**



Section 6 of 8



Symptoms

Description (optional)

In the 6 month period BEFORE the elimination diet:

Description (optional)

Frequency of defecations *

- >1 /day
- 1 /day
- 3-6 times /week
- 1-2 times /week
- Fortnightly
- Other...

Duration of episodes: (When constipated, how long does each episode last?) *

- <1 day
- 1 day
- 2 days
- 3 days



- 5 days
- 6 days
- 7 days
- Other...

Abdominal pain associated with constipation *

- Never
- Occasionally
- Frequently
- All the time

Pain on defecation *

- Never
- Occasionally
- Frequently
- All the time

Excessive straining on defecation *

- Never
- Occasionally
- Frequently
- All the time



... (2) ... (3) ... (4) ... (5) ... (6) ... (7) ... (8) ... (9) ... (10) ...

- Never
- Once
- 2-5 times
- >5 times

Soiling accidents: *

- Never
- Once
- Twice
- Once a month
- Once a week
- Daily
- Other...

Blood in toilet bowl and/or paper *

- Never
- Occasionally
- Frequently
- All the time

AFTER the elimination diet:

Description (optional)



- >1 /day
- 1 /day
- 3-6 times /week
- 1-2 times /week
- Fortnightly
- Other...

Duration of episodes: (When constipated, how long does each episode last?) *

- <1 day
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days
- Other...

Abdominal pain associated with constipation *

- Never
- Occasionally
- Frequently
- All the time



Pain on defecation *

- Never
- Occasionally
- Frequently
- All the time

Excessive straining on defecation *

- Never
- Occasionally
- Frequently
- All the time

Anal tears: (Did your child split their bottom during or after defecation?) *

- Never
- Once
- 2-5 times
- >5 times

Soiling accidents: *

- Never
- Once
- Twice
- Once a month



- Daily
- Other...

Blood in toilet bowl and/or paper *

- Never
- Occasionally
- Frequently
- All the time

After section 6 [Continue to next section](#)

Section 7 of 8

Severity of Constipation

Description (optional)

BEFORE the diet

Description (optional)

Constipation *

0 = does not prevent child from doing day-to-day activities

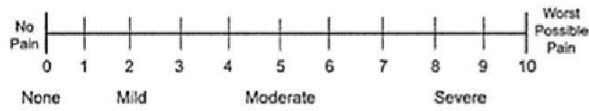
5 = sometimes prevents child from doing day-to-day activities

10 = prevents child from doing daily activities most of the time e.g. playing with friends, skipping school etc



No effect Prevents activity

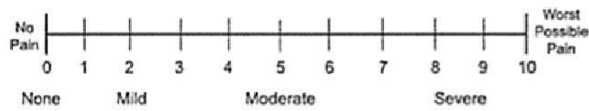
Abdominal pain associated with constipation *



0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

Pain on defecation *



0 1 2 3 4 5 6 7 8 9 10

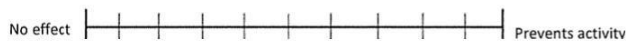
No pain Worst possible pain

AFTER the diet

Description (optional)

Constipation *

0 = does not prevent child from doing day-to-day activities
 5 = sometimes prevents child from doing day-to-day activities
 10 = prevents child from doing daily activities most of the time e.g. playing with friends, skipping school etc



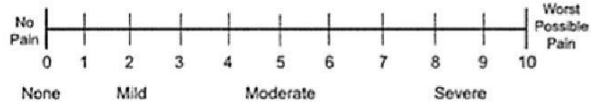


Constipation *

0 = does not prevent child from doing day-to-day activities
 5 = sometimes prevents child from doing day-to-day activities
 10 = prevents child from doing daily activities most of the time e.g. playing with friends, skipping school etc



Abdominal pain associated with constipation *



Pain on defecation *

